**Tobacco Exposure Screening & Action Form**

**Step 1: For you to fill out.**

Date: ___________ Patient’s Name: __________________________

Relationship to Patient (circle one):
- Mother
- Father
- Other: __________________________

Does your child live with anyone who smokes tobacco?
- Yes
- No
  
  If yes, who? __________________________

Have you used a tobacco product or vaping product, even a puff in last 7 days?
- Yes
- No, quit in past year
- No, quit over a year ago
- No, never

If you smoke, how interested are you in quitting?
- A lot
- Some
- A little
- Not at all

If you smoke, do you want to learn about resources to help you quit?
- Yes
- No
- Not sure

Does anyone smoke or vape in your home ever?
- Yes
- No

Does anyone smoke or vape in your car ever?
- Yes
- No
- No car

**Step 2: For the doctor/nurse to fill out**

**Provider Interventions:**

- Advise establishing tobacco free home and car
- Advise to quit smoking
- Provide TN Quitline card, explain service
- Fax referral to TN Quitline service
- Provide CEASE brochures
- Discuss and set quit date: __________________________

**Progress Notes:**

/__/__/__ : ________________________________________________
__________________________________________________________
/__/__/__ : ________________________________________________
__________________________________________________________
/__/__/__ : ________________________________________________